

S. No. 300
V. 10.48

FILED APR 7 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 8038

0241

BIRTH NO. _____ REG. DIST. NO. 41 PRIMARY REG. DIST. NO. 301 Registrar's No. 26

1. PLACE OF DEATH a. COUNTY <u>Clay</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>Clay</u>	
b. CITY OR TOWN <u>Epelsior Springs</u>	c. LENGTH OF STAY (in this place) <u>10 days</u>	c. CITY OR TOWN <u>Epelsior Springs</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Mitchell Clinic</u>		d. STREET ADDRESS (If rural, give location) <u>615 High St</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>AUSTON</u> b. (Middle) <u>ODLE</u> c. (Last) <u>ODLE</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Mar 3-1950</u>
---	--

5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Divorced</u>	8. DATE OF BIRTH <u>Aug 6 1884</u>	9. AGE (In years last birthday) <u>66</u>	10. UNDER 1 YEAR Months _____ Days _____	11. UNDER 10 HRS. Hours _____ Min. _____
--------------------	-------------------------------	--	------------------------------------	---	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labourer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>✓</u>	11. BIRTH PLACE (State or foreign country) <u>Epelsior Springs Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
---	--	---	--

13a. FATHER'S NAME <u>J. Hugh Odle</u>	13b. MOTHER'S MAIDEN NAME <u>Margaret Odell</u>	14. NAME OF HUSBAND OR WIFE <u>✓</u>
--	---	--------------------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Use no. of unknown) _____ (If yes, give war or dates of service) _____	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs Hattie Swafford Epelsior</u>	ADDRESS <u>Epelsior</u>
---	-------------------------------	---	-------------------------

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hypertension</u> DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<u>331X</u>	

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
------------------------------	--	--

21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
--	--	---

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____
---	--	----------------------------------

22. I hereby certify that I attended the deceased from Feb 22, 1950, to March 3, 1950, that I last saw the deceased alive on March 2, 1950, and that death occurred at 6:15 A.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Dr. J. C. McVey D.O.</u>	23b. ADDRESS <u>Epelsior Springs Mo</u>	23c. DATE SIGNED <u>3/4/50</u>
--	---	--------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>3/5/1950</u>	24c. NAME OF CEMETERY OR CREMATORY <u>New Garden</u>	24d. LOCATION (City, town, or county) (State) <u>Ray County Mo.</u>
---	---------------------------	--	---

DATE REC'D BY LOCAL REG. <u>3/5/50</u>	REGISTRAR'S SIGNATURE <u>Caroline Statching</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Hopa Funeral Home</u>	ADDRESS <u>Epelsior</u>
--	---	---	-------------------------

(Licensed Embalmer's Statement on Reverse Side)

SP95 MO

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

MAR 27

RECEIVED

District Health Officer No. 8,

District File Number.....

Date Filed 4-6-50

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

Student Embalmer No.

working under my personal supervision.

Signed James A. Moles
Licensed Embalmer No. 3296

Signed.....
Student Embalmer

P. O. Address Ex Springs Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.